



ISSUE DATE:

**June 15, 2009**

EFFECTIVE DATE:

**June 15, 2009**

NUMBER:

**OMHSAS-09-04**

SUBJECT:

Best Practice Guidelines for Family Involvement  
with Youth who are in Residential Treatment  
Facilities (RTF's)

BY:

Joan L. Erney, J.D.  
Deputy Secretary for Office of Mental Health

**SCOPE:**

This bulletin applies to County Mental Health/Mental Retardation Administrators, Residential Treatment Facilities (RTF's), County Child and Adolescent Services System Program (CASSP) Coordinators, Behavioral Health Managed Care Organizations (BH-MCOs) and Family Advocacy Organizations.

**PURPOSE:**

The purpose of this bulletin is to outline Best Practice Guidelines for family involvement with youth who are in RTF's.

**BACKGROUND:**

The 1999 United States Surgeon General's report on mental health described RTF's as "the second most restrictive form of care (next to inpatient hospitalization) for children with severe mental disorders." (p. 169).<sup>1</sup> The Surgeon General's report cited concerns such as the possibility of trauma associated with the separation from the family, difficulty re-entering the family or even abandonment by the family.

It is well documented that family involvement in all aspects of a child's mental health services, from the earliest screenings and assessment to the development and application of treatment plans, is important. Evaluation studies suggest that where there are positive outcomes from residential treatment care, gains are reported in areas such as clinical status, academic skills, and peer relationships. Whether these gains are sustained following treatment appears to depend on the supportiveness of the child's post-discharge environment.<sup>2</sup>

Pennsylvania's principles for serving children and their families support the belief that the vision, experiences, values, and preferences of family members and youth should always guide treatment and support planning.<sup>3</sup>

Practitioners and families recognize the following:

1. The family is most familiar with the child. The family can provide information on the child's diagnosis and treatment history, including use of medication; the child's strengths and needs; circumstances that affect the child's well-being; the child's education history and status; the family's culture and practices; and information on transition and ongoing support services.
2. Family is the core of a child's life. When shifting a child's behavior and treating serious mental health issues, the family should be engaged in the process to assure that changes are both realistic in the context of the family and the family has the skills, support and expertise to help sustain the changes. Family engagement assures a family's authentic participation in the treatment process, both while the child is in residential care and when the child returns to the family and community. The only exceptions to this principle should be when court directives restrict family member access or contact.<sup>4</sup>

### **DISCUSSION:**

Recently, the Child, Adolescent and Family Branch of the Substance Abuse and Mental Health Services Administration (SAMHSA) developed a policy statement on "Building Bridges between Residential and Community Based Service Delivery Providers, Families and Youth." One of the basic principles of this agreement is:

Residential and community-based services and supports must be thoroughly integrated and coordinated; and, residential treatment and support interventions must work to maintain, restore, repair, or establish youths' relationships with family and community. In the absence of biological family, or when precluded by the courts, family surrogates, adoptive families, as well as peers, school, and community relationships must be fostered in the most normative manner possible.<sup>5</sup>

### **DEFINITIONS:**

*Child:* An individual under 21 years of age.

*Family:* Parent(s), step-parent(s), caregiver(s), legal guardian(s) or custodian(s), foster parent(s), adoptive parent(s), sibling(s), half-sibling(s) and others as deemed appropriate.

*Residential Treatment Facility (RTF):* Premises operated in a 24-hour living setting in which behavioral health treatment is provided for one or more children with diagnosed mental illness, serious emotional or behavioral disorders, or a severe substance abuse condition and mental illness.

### **RECOMMENDED PRACTICES:**

Practices to guide the work of RTFs, many of which have been recommended by the Building Bridges Initiative, include but are not limited to the following:

### **Child Practices:**

- A child should be actively and meaningfully involved in everyday decision-making about the program and the child's care, and should have multiple opportunities every day to exercise choice in all aspects of care.
- A child should be given opportunities to learn and participate in age-, culturally- and developmentally-appropriate practical life experiences that are transferable to home and community (for example life skills), and are not in conflict with the culture, norms, and mores of the home.
- Treatment and support planning and implementation should comprehensively integrate educational objectives; program practices should recognize the importance and provide a variety of flexible supports to ensure educational achievement.
- Placement decisions should be modified as the needs of a child change, in keeping with directives from the courts if applicable.
- Treatment interventions and supports should be regularly and clearly monitored; changing treatment and support plans in response to needs should occur when necessary, especially in response to outcome or performance data or in response to requests from the child or the family.

### **Family Practices:**

- The family should be consulted routinely regarding everyday care and support of the child (for example, haircuts, school achievements), and have regular and meaningful roles in key decisions regarding the child's care. This is particularly important in understanding and respecting the family's culture and practices while the child is in care.
- The family should be actively engaged and supported in identifying and accessing the supports, services, or referrals needed, both for the identified child, any other siblings, themselves, or persons who are a part of the household, to support long-term positive outcomes for their family (for example, training, counseling, linkage to needed treatment services and support, assistance with concrete issues such as housing, transportation, etc.).

### **Child and Family Practices:**

- Formal and informal supports, services, and relationships identified and documented at intake should continue throughout residential treatment intervention.

- The child and family, including siblings, should have contact with one another as recommended by the child and family team; frequent, ongoing and meaningful child and family contact should be an agency priority that is fully and flexibly supported by agency practices.
- Child and family visits or telephone calls should not be cancelled or abbreviated as a result of a child's behavior, or used as a privilege or consequence. If a child is having behavioral difficulties, increasing the frequency of visits should be considered, if the family is able.
- The child, family and support team should guide the development and implementation of a transition plan that begins during the admission process; both RTF and community provider staff should participate and support all aspects of this planning and implementation. This process should begin with admission and be updated as needs change to assure appropriateness.
- Family therapy, when needed or desired by the family, should be ongoing and provided in a consistent manner and at times most convenient for the family.

### **Residential Treatment Facility and Community Supports:**

- RTF program practices should be guided by knowledge of the significant positive correlation of family engagement to youth positive outcomes. Program practices and staff training and support mechanisms should assist the residential provider in:
  - (1) reunifying a child with the family of origin; and/or
  - (2) establishing a permanent alternative family resource for a child not able to return to the family of origin.
- In keeping with the "culturally competent" CASSP principle, "services should recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies, and practices" that characterize the child and family's ethnic group.<sup>6</sup>
- The RTF should include development of family engagement skills in their regular staff trainings. Creative ways to deliver this topic should be regularly explored, and may include the use of current or past parents of children in the program, family advocates from recognized advocacy organizations, interactive exercises, etc.

### **FAMILY INVOLVEMENT:**

Recommendations for increasing family involvement include, but are not limited to, the following:

- The family should have the opportunity to tour the entire facility the first time they are on campus. This should include areas that provide support services, such as medical care, kitchen and laundry.
- The family should receive consistent and frequent telephone calls, emails, or faxed reports of the child's progress in treatment.
- If necessary, the family should be offered transportation by staff or other team members to facilitate the family's presence at team meetings and insure numerous visits to the child.
- The family should be notified within reasonable time frames and invited to attend any and all medical appointments that are outside of the facility.
- The family should be given opportunities to participate in volunteer opportunities according to their abilities, interests and availability. However, they should not be pressured to participate if they are unable to do so.

### **Residential Treatment Facilities:**

- Staff should help the family feel comfortable about leaving the child in the residential program, including answering questions about the program's safety history, and its history of injuries to children. The family should be offered reassurances, first and foremost, that the child will be safe.
- Staff should be trained and supported to interact with families respectfully and empathetically, with the understanding that families of children in residential facilities are experiencing significant stress that is different from what most people experience.
- Staff should encourage the family's self-advocacy and system advocacy skills by providing family centered resources from local, state, and national organizations.
- As part of the orientation to the RTF, the family should be made aware of opportunities to volunteer while their child is at the facility, such as chaperoning field trips or recreational activities.
- Clear and appropriate explanations of the terminology, routines and practices of the program should be provided to the family at admission and repeated as needed to support family comfort and understanding. The family should be assured that there is enough flexibility to modify the program to ensure respect for the culture of the child.
- Child accomplishments while in treatment should be celebrated by the family, RTF staff and other children, as appropriate and reasonable.
- A child should not be encouraged to exclude the family from involvement. If there are problems in the parent-child relationship, they should be clearly addressed in the treatment plan, subject to compliance with directives of the court.

## **COMPONENTS OF FAMILY INVOLVEMENT:**

### **1. Family Involvement Plan**

- The family should be actively involved in the development of the Family Involvement Plan. The plan should be developed within the first 14 days of admission to a residential treatment facility.
- The Family Involvement Plan should include the child and family strengths, needs and cultural values, and supports needed by the child and family while in residential treatment. It should also identify living arrangements for the child after the residential stay is complete.
- All participants should sign the original Family Involvement Plan and the Family Involvement Form. Questions 1 through 4 on the Family Involvement Plan Form should be answered by the child's family.
- Case records or progress notes should document the date the meeting occurred and list all participants at the meeting and the relationship of those individuals to the child.

### **2. Treatment Plan**

- The family should be actively involved in the development of the Treatment Plan.
- The Treatment Plan should identify the family's strengths, needs and cultural values identified in the family involvement plan and supports needed by the child and family while in residential treatment. It should also identify living arrangements for the child after the residential stay is complete.
- All participants should sign the original Treatment Plan and the Treatment Plan Form. Questions 1 through 4 on the Treatment Plan Form should be answered by the child's family.
- Case records or progress notes should document the date the meeting occurred and list all participants at the meeting and the relationship of those individuals to the child.

### **3. Family Visit**

- A family visit should occur within 30 days of the planned date of discharge or return to the community.
- Case records or progress notes should document the date the Family Visit occurred and list all participants at the meeting and the relationship of those individuals to the child.

#### **4. Discharge/Return to the Community Plan**

- The family should be actively involved in the development of the plan for return to the community or a transition plan for the child if placement/permanency goals and/or court directives otherwise define discharge goals.
- The Discharge/Return to the Community Plan should identify the family's strengths, needs and cultural values identified in the family involvement plan and treatment plan, supports needed by the child and family after discharge from the RTF, and living arrangements of the child after the residential stay is complete.
- All participants should sign the original Discharge/Return to the Community Plan and the Discharge/Return to the Community Form. Questions 1 through 4 on the Discharge/Return to the Community Plan Form should be answered by the child's family.
- Case records or progress notes should document the date and list all involved participants and the relationship of those individuals to the child.

#### **SUGGESTED SUPPORTS PROVIDED BY RTFs:**

- Provision of a specific contact person and 24-hour, general contact information for emergencies.
- Notification of health, medical, behavior and/or educational concerns and successes as they arise, as well as timely contacts as positive gains are achieved.
- Flexible scheduling of meetings.
- Information about rights and grievance procedures shared both verbally and in writing. This should include facility policies and procedures, including names and contact information for all relevant persons. This information should be displayed in all public areas of the RTF, and provided in printed form to the family.
- Comfortable and private space for meetings with staff and the child unless unsupervised contact with the child is prohibited by court order.
- Prompt return of phone calls confirmed by written documentation.
- Opportunity for the family to contribute comments and information about the child with the assurance that they will be included in the child's record.
- Easy access for the family to appropriate parts of the child's record.
- Support for transitions into or out of services or programs as identified in the treatment plan.

- Communication with all relevant family members and county case managers or county/Behavioral Health Managed Care Organization points of contact as agreed upon by the family and treatment team subject to prohibitions identified by the court.

## **ACTIONS:**

OMHSAS intends to work with counties, Behavioral Health Managed Care Organizations, families, advocacy organizations, and Residential Treatment Facility provider agencies to advance family involvement through application of the policy, principles, and practices of this Bulletin.

## **REFERENCES:**

<sup>1</sup>Office of the Surgeon General. (1999). *Mental health: A report of the Surgeon General*. Washington, DC: U.S. Public Health Service. Retrieved from <http://www.surgeongeneral.gov/library/mentalhealth/home.html>

<sup>2</sup>Hair, H. J. (2005). Outcomes for children and adolescents after residential treatment: A review of research from 1993-2003. *Journal of Child and Family Studies*, 14(4), 551-575.

<sup>3</sup>Core Principles of Pennsylvania's Child and Adolescent Service System Program (CASSP). (1995). Harrisburg, PA: Office of Mental Health and Substance Abuse Services.

<sup>4</sup>Brock, L., Burrell, J., & Tulipano, T. (2006). NDTAC Issue Brief: Family involvement. Washington, DC: American Institutes for Research, National Evaluation and Technical Assistance Center for the Education of Children and Youth Who Are Neglected, Delinquent, or At Risk. Retrieved from [http://www.neglected-delinquent.org/nd/docs/NDTAC\\_issuebrief\\_family.pdf](http://www.neglected-delinquent.org/nd/docs/NDTAC_issuebrief_family.pdf)

<sup>5</sup>Building bridges between residential and community-based service delivery providers, families and youth. (2006). Joint Resolution to Advance a Statement of Shared Core Principles. Washington, DC: Child Welfare League of America. Retrieved from <http://www.cwla.org/programs/groupcare/buildingbridgesstatement.pdf>

<sup>6</sup>CASSP Principles, 1995.

### **COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:**

Sherry Peters, Bureau of Children's Behavioral Health Services, Office of Mental Health and Substance Abuse Services, P.O. Box 2675, Harrisburg, PA 17105, telephone 717-772-7855 or [shepeters@state.pa.us](mailto:shepeters@state.pa.us).